CHAPTER VI

UTILIZATION REVIEW AND CONTROL

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INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by recipients. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) conducts periodic utilization reviews on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control requirement procedures conducted by DMAS.

COMPLIANCE REVIEWS

The Department of Medical Assistance Services routinely conducts compliance reviews to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R., Part 455. Providers and recipients are identified for review by systems generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases using available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

Statistical sampling and extrapolation may be used in a review. The Department may use a random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the amount of invalid payments in the audit sample are compared to the total invalid payments for the same time period, and the total amount of the overpayment is estimated from this sample. Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In

addition, Medicaid may restrict or terminate the provider's participation in the program due to the provision of poor quality services or of any of the above problems.

Corrective actions for recipients include education on the appropriate use of health care, restriction to designated providers for utilization control, recovery of misspent funds, and referral for further investigation of allegations of fraudulent activities. Loss of Medicaid coverage can result from a conviction of Medicaid fraud.

HOME HEALTH PROGRAM

The home health agency and its staff must operate and furnish services in compliance with all applicable federal, State, and local laws and regulations. In addition, the home health agency must comply with accepted professional standards and principles that apply to professionals furnishing services. All personnel furnishing services must maintain liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. The clinical record or minutes of case conferences must establish that effective interchange, reporting, and coordination of patient care has occurred. A written summary report for each recipient must be sent to the attending physician at least every 60 days.

If the recipient is enrolled in MEDALLION, the attending physician must be the MEDALLION primary care physician (PCP), or there must be a referral for the service from the MEDALLION PCP. This referral may be obtained in writing or orally and must be documented in the recipient's' record.

Retention of Medical Records

A medical record containing pertinent past and current findings in accordance with accepted professional standards must be maintained for every recipient receiving home health services. In addition to the plan of care, the record must contain appropriate identifying information; the name of the physician; drug, dietary, treatment and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and once discharged, a discharge summary.

For recipients currently receiving a home health service, a copy of the plan of care, all supporting verifiable medical documentation, and all associated billing documentation must be kept on file at the location serving the recipient. For recipients no longer receiving a home health service, completed plans of care, all supporting verifiable medical documentation, and all associated billing documentation must be retained by the provider for at least five years. (*State Plan for Medical Assistance*, Supplement 1 to Attachment 3.1-A&B, Section 7-D, 1.h., 7.) If a recipient is transferred to another home health agency, a copy of the record must be forwarded to the new home health provider.

Medical record information must be safeguarded against loss and unauthorized use. The home health agency mus have written procedures in place that govern the use and removal of records and the conditions for the release of information. The recipient's written consent is required for the release of information not otherwise authorized or required by law.

DOCUMENTATION REQUIREMENTS FOR HOME HEALTH SERVICES

The documentation of home health services shall, at a minimum:

a. Describe the clinical signs and symptoms of the recipient's illness;
b. Document an accurate and complete chronological picture of the recipient's clinical course and treatments;
c. Document all treatment rendered to the recipient in accordance with the plan with specific attention to the frequency, duration, modality, response, and identify who provided the care (include the full name, title and date);
d. Document the changes in the recipient's condition;
e. Include all plans of care;
f. Document drugs and treatments as ordered by the physician;
g. Document that the home health agency staff is checking all medicines a recipient is taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies and contraindicated medication and must promptly report any problems to the physician; and
h. Describe the efforts to discharge the recipient from home health services.

If a specialist admits the recipient to home health, the MEDALLION PCP must have made the referral to the specialist. The specialist must maintain documentation of coordination of services with the MEDALLION PCP.

NOTE: Home health agencies must follow all Virginia Department of Health Professions' guidelines on qualifications and supervision of staff.

General Documentation Requirements

Whenever services cannot be provided as ordered by the physician (e.g., in the case of the unavailability of a service, staff absences, etc.), the attending physician must be notified and the medical record must reflect the attempts made by the home health agency to provide the service and reasons why the service could not be provided as ordered. Documentation describing the efforts to provide the service and contacts to the physician must be maintained in the medical record.

Any ordered service must begin within three (3) days of the physician order, unless the physician's order specifies otherwise. When the home health agency is unable to provide an ordered service within three (3) days, the physician must be notified immediately and consideration given to referring the recipient to another home health agency. If the physician orders that the services must begin earlier, the home health agency must provide the services within the ordered time frame. If the home health agency is unable to provide the requested services within the requested time frame, the home health agency must notify the physician and consideration must be given to referring the recipient to another home health agency. Documentation of efforts made to provide the services, physician notification, and referrals to other providers must be maintained in the recipient's record.

At no time should wite-out be used in a recipient medical record. If corrections are required, the error should be crossed out, corrected, initialed and dated by the person who

made the corrections.

Physician Documentation Requirements

The recipient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his or her license. The physician may be the recipient's private physician or a physician on the staff of the home health agency or a physician working under an arrangement with the assisted living facility (ALF) which is the recipient's residence or, if the agency is hospital-based, a physician on the hospital staff.

Recipients are accepted for treatment on the basis of a reasonable expectation that the recipient's medical and nursing needs can be met adequately by the home health agency in the recipient's place of residence. Care follows a written plan of care established and reviewed by a physician as often as the recipient's condition requires, but at least every 60 days. The requested services must be necessary to carry out the plan of care and must be related to the recipient's condition.

The plan of care, developed in consultation with the appropriate qualified agency personnel, must include the following applicable information:

- Diagnosis and prognosis;
- Functional limitations;
- Activities permitted;
- Mental status;
- Safety measures to protect against injury;
- Orders for medications and treatments;
- Orders for dietary or nutritional needs;
- Orders for nursing and therapeutic services;
- Orders for home health aide services;
- Orders for medical tests, including laboratory tests and x-rays;
- Measurable goals for treatment for all disciplines within established time frames;
- Frequency and duration of all services;
- Rehabilitation potential; and
- Instructions for a timely discharge or referral.

A written physician's statement, which may be in the form of the physician’s orders on the home health certification plan of care, located in the medical record must certify that:

- The recipient needs nursing care on an intermittent basis; the recipient needs physical or occupational therapy or speech-language pathology services; and

- A plan for furnishing such services to the individual has been established and is periodically reviewed by a physician.

The physician is responsible for signing (name and title) and dating (month, day, and year) this required documentation. Any dictated typed reports must be signed and dated by the physician. A required physician signature for Medicaid purposes may include signatures,

written initials, computer entry, or rubber stamp initialed by the physician. However, these methods do not preclude other signature requirements that are not for Medicaid purposes. If the physician chooses to use a rubber stamp on documentation requiring his or her signature, the physician whose signature the stamp represents must provide the home health agency administration with a signed statement to the effect that he or she is the only person who has the stamp and is the only one who will use it. The physician must initial and completely date all rubber-stamped signatures.

The initial physician certification plan of care must be signed and dated by the physician within 21 days of the beginning of home health services. DMAS will not reimburse the home health agency for services provided prior to the date of the physician's signature when the signature is not obtained within 21 days of the beginning of home health services.

Subsequent physician recertification plans of care are required at intervals of at least once every 60 days. These recertifications must be signed and dated by the physician, who reviews the recertification, within 60 days of the previous plan of care. DMAS will not reimburse the home health agency for services provided prior to the date of the physician's signature when the signature is not obtained within 60 days of the start of the previous plan of care. The recertification plan of care must include any orders obtained as a result of modifications to the previous plan of care, which remain in effect, and include updated goals and time frames for goal achievement for all services ordered. The physician must approve, in writing, modifications to the plan of care. DMAS will not reimburse the home health agency for services provided during a time period for which there is no valid initial or recertification plan of care.

A verbal order that necessitates a change in the current plan of care must be signed and dated by the physician. The verbal order must be received by a registered nurse. If rehabilitative therapies are the only services ordered by the physician, a qualified licensed therapist may receive the verbal order.

Nursing Documentation Requirements

The following components are required for nursing documentation:

Nursing Assessment - A thorough evaluation must be made by a registered nurse at the time of admission to home health nursing services. This initial evaluation must be maintained in the recipient record throughout the duration of treatment and must contain a history of the medical conditions; a review of the physical systems and the identification of the physical problems and disabilities; and a psycho-social assessment which must include the identification of support persons, environmental issues, and needs. The evaluation should also include the reason for admission to home health services.

Nursing Care Plan - Nursing care plans based on an admission assessment are required for all recipients and must indicate the actual or potential recipient/family needs, measurable goals and objectives, specifically state the method by which they are to be accomplished, and include time frames for goal achievement. Nursing care plans must be updated as the recipient's nursing care needs change. If home aides

are to be utilized, the nursing care plan must reflect their duties and frequency. If the nursing care plan is a part of the home health certification plan of care, all of the above documentation must be identified.

Nursing Visit Notes - Visit notes are required at the time of each visit and must describe the treatment and/or instruction provided. In addition, the notes must address the medical status, treatment and/or instructions given for any special nursing procedures and identification and resolution of acute episodes. Treatment and care must be in accordance with the provisions of the plan of care.

Comprehensive Nursing Visit Documentation Requirements

Reimbursement at the comprehensive rate is based on the complexity of the skilled nursing procedures ordered and performed during each visit and not on the complexity of the overall case. Authorization of extension of comprehensive skilled nursing visits will only be considered after a comprehensive visit has been conducted. These visits must be submitted to the DMAS authorization contractor for review. A visit to determine if the patient and/or caregiver performed a procedure as previously taught would not be considered reimbursable at the comprehensive visit rate. An example of this type of visit would be the assessment by the nurse that the patient or caregiver had already performed a procedure correctly, prior to the nurse's visit, and no further complex teaching/treatment was required or medically necessary by the nurse.

The following examples identify some situations and describe the minimum documentation requirements necessary to support the appropriateness of billing at the comprehensive visit rate. These examples and individual cases must be within the context of the definition of comprehensive visits. Many recipients and caregivers learn from short, focused teaching sessions. These short, focused sessions do not qualify for reimbursement at the comprehensive rate.

Diabetic Instruction

- Documentation must show that the assessment, direct care, or teaching requires an extensive length of time and that the recipient and/or caregiver are able to comprehend in-depth instruction. Arrival and departure times must support the extended duration of the visit for the purpose of teaching the recipient or caregiver and the complexity of the skilled procedures performed.

- The teaching plan must be clearly outlined.

- Visit notes must outline all instructions given and the ability of the recipient or caregiver to return the demonstration.

Wound Care

- The recipient must have multiple or extensive wounds.

- Treatment orders must include multi-step procedures requiring longer periods of time than routine wound care.

- All documentation as to the size, depth, appearance, color, odor, drainage, and treatment provided must be included in each visit note.

- Arrival and departure times must support the extended duration of the visit for the purpose of teaching the recipient or caregiver and the complexity of the skilled procedures performed.

- Visit notes must outline all instructions given and the ability of the recipient or caregiver to return the demonstration.

Intravenous (I.V.) Infusion

- Documentation must show the arrival and departure times, supporting an extended duration of the visit for the purpose of teaching a recipient or caregiver to administer I.V. fluids or medications and the complexity of the procedures performed.

- Visit notes must outline all instructions given and the ability of the recipient or caregiver to return the demonstration.

- If the nurse is required to stay with the recipient throughout the administration of an I.V. medication, the physician orders and visit notes must identify the recipient-specific risk factors requiring the continuous monitoring by the nurse. Additionally, the specific requirements for monitoring, reporting, and skilled interventions must be detailed in the physician's orders and documented in each visit note.

NOTE: Routine I.V. administration of fluids for hydration or medication which have no identified significant risk factors requiring nurse monitoring are not considered high-tech even if the task takes eight hours. Further, DMAS does not consider a charge for a second skilled visit the same day as reasonable and necessary when the visit is for the sole purpose of discontinuing an I.V. when there is no other skilled intervention required.

Instruction to Non-English Speaking Recipients or Caregivers

- Exact circumstances must be documented regarding the fact that no acceptable means to facilitate the communication has been established (no interpreter, no staff member who speaks the language of the recipient or caregiver, no English speaking family members, friend, or other support); and

- Documentation must also be specified to the duration of the visit (arrival and departure times) and the type of service rendered to support the complexity of the procedures performed and/or the instructions given to the recipient and/or caregiver.

NOTE: These situations should be very rare. Once a means of communication has been established, reimbursement at the comprehensive visit rate will no longer be considered necessary.

Extended Time Due to the Age/Condition of the Recipient

- Documentation must describe the condition, the skilled procedure performed, and the difficulty resulting from the particular set of problems in situations (i.e. attempting to start peripheral I.V.s on a child with spasticity or an adult with fragile veins.

- Visit notes must identify arrival and departure times and include a clear description of the efforts to complete the physician ordered skilled procedure and why these efforts were unsuccessful.

- Visit notes must also document what steps the nurse took to either obtain additional orders or have another skilled professional attempt the procedure.

NOTE: If another nurse were successful in the performance of the skilled procedure, this visit would not be considered reimbursable at the comprehensive visit rate.

Visits that require additional nursing time because of social welfare limitations do not constitute reimbursement at the comprehensive nursing visit rate. Examples may include, but are not limited to:

- The recipient has no community support for meals, transportation, etc.;

- The recipient lives alone and has no family support; or

- The housing conditions are inappropriate or unsafe.

All nursing documentation must be fully signed with full name, title and dated completely with month, day and year.

<u>Rehabilitative Therapies Documentation Requirements</u>

If physical therapy, occupational therapy, or speech-language pathology services are ordered by the physician and rendered to a home health recipient, there must be an initial assessment conducted by a qualified therapist. The initial assessment must include current functional deficits, clinical status, symptoms of the recipient's condition, including the diagnosis, and identification of needs indicating rationale for therapeutic interventions, prior to the delivery of home health therapy services. The initial assessment must also document an accurate and complete chronological picture of any clinical course of other therapy treatments, including any prior home health or rehabilitation treatments. A plan of care specifically designed for the recipient must be established and must include

measurable short and long-term goals which describe the anticipated level of functional improvement and include time frames for improvement and/or goal achievement. This plan must be reviewed and updated as needed, but at least every 60 days. This includes updating goals and achievement dates that are identified on the care plan. When all the established long-term goals have been met based on the achievement dates and there are no other established long-term goals identified on the plan of care, the therapist must reevaluate the plan of care to determine if it is appropriate for services to continue. If there are no other long-term goals to be established, the recipient should be discharged from services. In some instances, it may be appropriate to set long-term goal achievement dates beyond the current home health 60-day certification plan of care time frame; however, these long-term goals must be assessed at least every 60 days for any revisions necessary. If the therapy plan of care is part of the home health certification plan of care, all required documentation must be identified.

Progress notes must be written in the recipient's medical record at the time of each visit to a home health recipient and must include the type and duration of the treatment given, the recipient's response to the treatment, and progress or lack of progress toward established goals. All entries to the medical record must be signed and fully dated by the provider of treatment, including full name and title. Treatment and care must be provided in accordance with the plan of care. The progress note must also indicate any education conducted, the recipient/caregiver's ability to carry out the instructions given and any home program established. None of the above services are reimbursed by DMAS without a current physician's order which specifies the service treatment plan, the frequency and duration of the provision of the service.

If the recipient is receiving therapy services from more than one provider (e.g., home health and outpatient or school rehabilitation), the recipient's medical record must show documentation of coordination of these services, including goals, time frames for goal accomplishment and progress or lack of progress towards the established goals coordination efforts.

Home Health Aide Documentation Requirements

Written instructions for home health aide services must be documented in the medical record prior to the provision of services. These instructions must clearly identify all the services the aide is expected to perform for the recipient in the place of residence. These instructions must be completely signed and dated by the registered nurse or licensed qualified therapist.

Home health aide visits must be documented in the recipient's medical record for each visit to the recipient in his/her place of residence. This documentation must include identification of the services provided by the home health aide. All home health aide visit notes must be signed and fully dated with the month, day and year, by the aide who performs the services. Documentation must also reflect that the services are being provided in accordance with the home health plan of care. Home health aide documentation should also include any information that identifies why the recipient or home health aide is unable to participate in meeting the goals of home health aide services.

Supervision of Home Health Aide Services

Home health aide services must be provided under the supervision of a registered nurse or licensed, qualified therapist. This documentation may be in the form of a visit note, by the registered nurse or licensed, qualified therapist for the purpose of the supervisory visit of the home health aide only and must be signed and fully dated with the month, day and year. The results of the supervisory visit must be documented (e.g., if the home health aide is performing services in accordance with the plan of care and the response of the recipient and/or caregiver). If the supervisory visit is conducted in conjunction with the skilled visit, the documentation must reflect that the supervisory task was performed and the results (i.e., if the home health aide is performing services in accordance with the plan of care and the response of the recipient and/or caregiver.)

When only home health aide services are provided, a registered nurse must make a supervisory visit to the recipient's residence at least once every 60 days. Each supervisory visit must occur when the aide is providing care. The supervisory visit is not reimbursable by the Medicaid program.

When skilled nursing services, in addition to home health aide services, a registered nurse must make a supervisory visit to the recipient's place of residence at least every two weeks (either when the aide is present or absent). However, all supervisory visits should not be made when the aid is absent. This supervisory only visit is not reimbursable by the Medicaid program.

When rehabilitative therapy (physical, occupational and/or speech-language pathology therapies, in addition to the home health aide) are the only services provided, a licensed qualified therapist may make the supervisory visit instead of the registered nurse.

Discharge Planning

Discharge planning must be an integral part of the overall treatment plan which is developed at the time of admission to home health services. Discharge planning documentation for all disciplines providing services to the recipient must include any or all of the following:

- Anticipated improvements in limitations or health care needs;
- Time frames necessary to meet the goals;
- Feasibility of alternative care, including options for other Medicaid covered services;
- Documentation that the recipient and/or caregiver participated in the discharge planning process; and
- Discharge planning activities were explored at least every 60 days, or as often as changes occur.

Reimbursement for home health services may be discontinued when further progress toward established goals are unlikely or it is appropriate that care and/or therapy treatments can be maintained or provided by the recipient, caregiver(s), care aide, etc. In instances where care can be provided by someone other than the health care professional or home health aide, or there is no further progress toward established goals, DMAS will not reimburse for services rendered. Specifically, if no further progress is observed, discharge

from home health services would be appropriate and expected. Each discipline must promptly prepare a discharge summary to be sent to the physician. The summary should document the recipient's progress or lack of progress and identify the treatment goals that were met or not met. Recommendations for follow-up care should be included.

UTILIZATION REVIEW RESPONSIBILITIES OF THE HOME HEALTH AGENCY

The agency must maintain records on each recipient in accordance with accepted professional standards and practices. Recipient records must be complete, accurately documented, readily accessible, and systematically organized. All entries in the recipient records must be signed with the first initial, last name, and professional title of the author and completely dated with the month, day, and year. Home health agencies must have current physician orders for services rendered, including orders to discontinue services if recipients are discharged prior to the end of the current certification period. Services must be provided within the requested time frames.

The home health agency must have written policies requiring an overall evaluation of the agency's total program at least once a year by a group of professional personnel (or a committee of this group), home health agency staff, and consumers, or by professional people outside the agency working in conjunction with consumers. The evaluation must consist of an overall policy and administrative review and a clinical record review. The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient. Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records.

As a part of the evaluation process, the policies and administrative practices of the agency are reviewed to determine the extent to which they promote recipient care that is appropriate, adequate, effective, and efficient. Mechanisms must be established in writing for the collection of pertinent data to assist in the evaluation.

At least quarterly, the appropriate health professionals, representing at least the scope of the program, must review a sample of both active and closed medical records to determine whether established policies are followed in furnishing services directly or under contract. There must be a continuing review of the medical records for each 60-day period that a recipient receives home health services to determine the adequacy of the plan of care and the appropriateness of the continuation of care.

UTILIZATION REVIEW RESPONSIBILITIES OF DMAS

Under federal regulations, DMAS must provide for the continuing review and evaluation of the care and services covered by DMAS. This includes a review of the utilization of the services rendered by providers to recipients. Desk and on-site reviews of each Medicaid participating home health provider will be made periodically, and may be unannounced. The utilization review will include a professional review of the services provided by the home health provider with respect to:

- The care being provided to the recipients;

- The adequacy of the services available to meet current health needs and to provide the maximum physical and emotional well-being of each recipient;
- The necessity and desirability of the continued participation in home health services by the recipient;
- The feasibility of meeting the recipient's health needs in alternate care arrangements; and
- The verification of the existence of all documentation required by Medicaid to indicate that reimbursement coincides with services provided.

Other visits may be made to follow-up on deficiencies or problems, to investigate complaints, and to provide technical assistance. A plan of correction may be requested based on the findings of the visit. All utilization reviews will be followed-up with a written report to the home health agency outlining any areas out of compliance with DMAS regulations and policies. Services not found to be appropriate or not specifically documented in the recipient's medical record as having been rendered will be deemed not to have been rendered, and no reimbursement will be provided. In addition, no reimbursement will be allowed if documentation does not reflect that services provided met program criteria.

PROVIDER APPEAL OF UTILIZATION REVIEW ACTIVITIES

Payment to the home health provider may be denied when the provider has failed to comply with applicable DMAS laws, regulations, or DMAS policy guidelines.

The home health provider has the right to request reconsideration of retraction of reimbursement for home health services provided. The request for reconsideration and all supporting documentation, must be submitted within 30 days of receipt of written notification to:

Program Administration Supervisor II,
Facility & Home Based Services Unit,
Long Term Care and Quality Assurance Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

DMAS will review the documentation submitted and provide the home health provider with a written response to the request for reconsideration. If the denial is upheld, the provider has the right to appeal the reconsideration decision by requesting an informal fact finding conference within 30 days of receipt of written notification of the reconsideration decision. The provider must submit a detailed statement of the factual and legal basis for each item under appeal. The notice of appeal and supporting documentation must be sent to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If the denial is upheld, the provider has the right to appeal the informal fact finding decision by requesting a formal evidentiary appeal within 30 days of written notification of the informal fact finding decision. The notice of appeal and supporting documentation must be sent to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

RECIPIENT APPEALS

If the denied service has not been provided to the recipient the denial may be appealed only by the recipient or his or her legally appointed representative. Recipient appeals must be submitted within 30 days of the receipt of the denial of written notification to:

Director, Division of Appeals
Department of Medical Assistance Services
600 E. Broad Street, Suite 1300
Richmond, VA 23219

Any decision concerning the continued placement made by the attending physician is not appealable to DMAS.

RECIPIENT RIGHTS

The recipient has the right to confidentiality of the clinical records maintained by the home health agency. The agency must advise the recipient of the agency's policies and procedures regarding the disclosure of clinical records.

Before the care is initiated, the home health agency must inform the recipient, orally and in writing, of the extent to which payment may be expected from Medicare, Medicaid, or any other federally funded or aided program known to the home health agency; the charges for services that will not be covered by Medicare; and the charges that the recipient may have to pay.

The recipient has the right to be advised orally and in writing of any changes in the information regarding recipient's rights as they occur. The home health agency must advise the recipient of these changes as soon as possible, but no later than 30 working days from the date that the agency becomes aware of a change. The recipient has the right to be advised of the availability of the toll-free complaint line established by the Department of Health, Division of Licensure and Certification. The telephone number is 1-800-955-1819.

When the agency accepts the recipient for treatment or care, the agency must advise the recipient in writing of the telephone number and that the purpose of the hotline is to receive complaints or questions about local home health agencies.

Advance Directives

All home health agencies participating in the Medicare and Medicaid programs must provide adult individuals with written information regarding an individual's right to make medical care decisions. This includes the right to accept or refuse medical treatment and the right to formulate advance directives.

The term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law and relating to the provision of such care when the individual is incapacitated. The law does not prohibit any health care provider (or any agent of such provider) from refusing, as a matter of conscience, to implement an advance directive. Further, the law does not require individuals to execute an advance directive. Under the law, home health agencies must:

- Provide all adult individuals with written information about their rights under State law to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives as well as the provider's written policies respecting the implementation of such rights;
- Inform patients about the home health agency's policy on implementing advance directives;
- Document in the patient's medical record whether he or she has signed advance directive;
- Not discriminate against an individual based on whether he or she has executed an advance directive; and
- Provide for educating staff and the community on advance directives.

REFERRING RECIPIENTS TO CLIENT MEDICAL MANAGEMENT

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) in the Department of Medical Assistance Services. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and/or pharmacy in the Client Medical Management Program (CMM). (See "Exhibits" at the end of Chapter I for defined information on the CMM program). If CMM enrollment is not indicated, RMU staff may educate recipients on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. Voice mail after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Program Integrity Section
Division of Cost Settlement and Audit
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 786-6548
CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the recipient and a brief statement regarding the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Since payment of claims is made from both State and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or State court. The Program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable State and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Program Integrity Section

Division of Cost Settlement and Audit
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 E. Main Street, 5th Floor
Richmond, Virginia 23219

Recipient FraudAllegations about fraud or abuse by recipients are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries.

If it is determined that benefits to which the individual was not entitled were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit
Program Integrity Section
Division of Cost Settlement and Audit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219